SOUTHEAST MISSOURI STATE UNIVERSITY

Please check the appropriate Health Care Component

❒Self-funded Health Plan ❒Health Clinic ❒Autism Center

REQUEST FOR RESTRICTION OF USE AND DISCLOSURE OR REVOCATION OF AUTHORIZATION

1. I, ___________________________________hereby [please initial all that apply]:

   _______ revoke the Authorization to use or disclose protected health information related to _____________ ______________________________ dated ________________________ [Sign and return below].

   _______request a restriction on the **use** of the protected health information related to __________________ ____. [Proceed to question 2.]

   _______ request a restriction on the **disclosure** of the protected health information related to____________ ____ [Proceed to question 3]

2. Complete this question 2 only if you are requesting a limitation on the **use** of your protected health information.

   a. I wish to limit the use of the following protected health information [please specifically describe the information you wish to restrict, including the date of the service, the treatment rendered and the type of record]: ____
   ____

   b. I request that the above listed protected health information not be used for the following purpose(s): ____
   ____
   ____

3. Complete this question 3 only if you are requesting a limitation on the **disclosure** of your protected health information.

   a. I wish to limit the disclosure of the following protected health information [please specifically describe the information you wish to restrict, including the date of the service, the treatment rendered and the type of record]: ____
   ____

   b. I request that the above listed protected health information not be disclosed to the following individuals and/or entities [please provide the name of the individual or entity and his/her/its relationship to you]: ____
   ____

4. Circle question 4 if you have paid out of pocket for a health care item or service and you wish to limit disclosure to your health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), except as otherwise required by law.

Dated: ________________________________ ____

Signature of Patient or Personal Representative

____

Description of Personal Representative's Authority

FOR OFFICE USE ONLY
The Covered Entity hereby:

_______ agrees to the requested restriction.
_______does not agree to the restriction (does not apply to question 4).

_______________________ ______________________________________

Dated Signature